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The Behaviour 'Crisis': Young Children's Mis/understandings of the Identities of ADHD

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Abstract

This paper explores the mis/understandings two young children have of the behaviour 'crisis' besetting our schools. Specifically, this paper examines semi-structured interview talk with boys aged between six and eight years of age who were labelled by medical specialists as exhibiting Attention Deficit Hyperactivity Disorder (ADHD)[1], that is, behaviour that is considered to be 'inappropriate'. The data suggests that the boy's mis/understandings of the identities of ADHD are produced from normalised school child discourses and recontextualised medical discourses. The uptake of these discourses leads to the boys constructing ADHD identities as deviant and diseased, and requiring medication. Possible consequences for the boys' mis/understandings are discussed and those working with such labelled students are implored to assist them in better understanding the origins and treatment of labels and dealing with the outcomes of their socially constructed identities.

The Behaviour 'Crisis'

In as many days, from 28 February through until 2 March, 2005, Queensland's leading daily newspaper ran three articles that reported on the behaviour 'crisis' in Queensland schools. The first of these articles stated that 'hundreds of state teachers have received payouts for psychological illnesses and mental disorders since June 2002 with most of those blamed on dealing with violent and bulling students' (Gregory, 2005). According to the article, 'in the past two financial years $5.75 million was outlaid in WorkCover payments to 440 stressed-out educators found to be the victims of physical, mental and verbal abuse' (Gregory, 2005). The second article highlighted the plight of one mother whose two sons, aged seven and eleven and 'diagnosed as having oppositional defiance disorder by health experts at the Mater Hospital', had been suspended from school for

[1] While some medical specialists and lay personnel incorrectly use the terms Attention Deficit Hyperactivity Disorder (ADHD) and Attention Deficit Disorder (ADD) interchangeably, the term ADHD has been adopted and used in this paper to refer to all who exhibit ADHD behaviours, as defined by the American Psychiatric Association (1994) manual.

'bad behaviour' (Allen, 2005a). The article reported the mother as describing the boys' behaviour as 'in crisis' and joining with teachers to call for 'increased funding for behaviour management in schools' (Allen, 2005a). The third article drew on Education Queensland's Annual Report for 2003-04 and stated that 'only 30 per cent of Queensland state high school students and fewer than 40 per cent of primary students are satisfied with behaviour in their schools' (Allen, 2005b). The article also stated that in 2004 'Queensland schools recorded more than 34 000 short-term disciplinary suspensions, more than 3 000 long-term suspensions, and 773 exclusions' (Allen, 2005b).

These stories, and the figures contained within, are simply alarming. They also describe and quantify the everyday reality of a significant number of teachers and students. The management of students' behaviour has long been an issue for education systems, teachers and students themselves, not only in Queensland, but throughout Australia. This paper is an attempt to enter into the furore that has re-surfaced in the media and report on research that examines students' mis/understandings of the behaviour crisis in primary schools. Specifically, this paper reports on and analyses interview data collected from two primary school students who have been labelled as exhibiting Attention Deficit Hyperactivity Disorder (ADHD) behaviour. According to the American Psychiatric Association, ADHD is as a 'developmental disorder that may be characterised by socially disruptive behaviour, inappropriate levels of attention, impulsiveness, hyperactivity, or a combination thereof' (1994:78). By definition, these students present their teachers with immense difficulties, yet there is a dearth of studies that examine the perceptions of students who are labelled as such. This paper explores what two young boys labelled as having ADHD behaviours have to say about the origins, management and outcomes of the ADHD label. This paper will be presented in four sections. The first section reviews the literature on ADHD, and in doing so, critiques current theories about the origins, diagnosis and management of ADHD behaviours. The second section introduces the research study, while the third section examines the interview data collected. The final section addresses some education implications for those working with students labelled as ADHD.

ADHD: Current Theories on its Origin, Diagnosis and Management

A review of the literature indicates a good deal of uncertainty about the origin, diagnosis and management of ADHD behaviours. Researchers have proposed a variety of causal factors about the origins of ADHD behaviours. According to some, neurological, hereditary (Grantham, 1999; Singh, 2003), pre- and post-natal factors, and toxic influence can all lead to the development of ADHD behaviours. Other researchers suggest that environmental factors, such as social expectations, inconsistent parenting and/or ineffective educational practices could exacerbate the symptoms (see Barkley, 1990; Exley, 1997; Hinshaw et al, 1997; Brown, 2000; Singh, 2003; Lorch et al, 2004; Antrop, Roeyers & De Baecke, 2005). Singh (2003, p. 309) notes that a core limitation of much of the research on ADHD is its focus on boys labelled as ADHD and mothers' perceptions of ADHD. This may be due to the perception that boys have a higher tendency to show hyperactive and aggressive behaviours, thus being referred for evaluations more frequently than girls (Brown, 2000). There is, however, a dearth of

literature on girls labelled as ADHD, fathers' and students' perceptions of ADHD behaviours.

It also seems an equivalent amount of controversy exists over the diagnosis of ADHD. Behaviour checklists are commonly used for the diagnosis of ADHD. These checklists are often filled out by teachers, who are usually not trained in the field of behaviour diagnosis (Vereb & DiPerna, 2004). Moreover, contradictory empirical studies would suggest that the checklists are inappropriate for the diagnosis of ADHD behaviours. For example, Antrop et al's (2005) empirical study found that playtime did not effect students' level of hyperactive behaviour post-playtime. Yet Jarrett et al's (1998) study found that children with ADHD behaviours were more quiet and cooperative after playtime. Demaray, Schaefer and Delong's (2003, p. 593) national survey of 316 practicing school psychologists found that approximately 30 percent reported using personality and projective measures, such as drawings, ink blots, and story telling, in their assessment of ADHD despite them being labelled as 'reliably discriminatory' (Gordon & Barkley, 1998) and of 'little predictive validity' (Barkley, 1998). Moreover, much of the literature states that ADHD is often misdiagnosised, that is a child's behaviours are attributed to ADHD when in actuality they are caused by or related to some other condition or trait. For example, Hartnett, Nelson and Rinn (2004) suggest that gifted students often exhibit similar sets of behaviour to children labelled as ADHD. In addition, Demaray et al's (2003, p. 593) research found that half of the 316 school psychologists who participated in their study did not identify particular measures used to assess for comorbid disorders. In short, there is not a true and definitive test for ADHD. Diagnosis is subjective in that it is more often than not dependent upon teachers' observations of students. Many children are assessed, diagnosed and treated for ADHD without undergoing multiple methods of assessment (see Brown, 2000).

In terms of managing ADHD behaviours, much of the literature suggests the uptake of a multicomponent approach (see MTA Cooperative Group, 1999; Edwards, 2002). Yet stimulant medication in isolation is still the most common choice of treatment despite findings that it is at best 'potentially helpful' for children exhibiting ADHD behaviours (Kollins, Barkley, DuPaul, 2001) and will never 'cure' them of the 'condition'. The three most commonly taken stimulant medications are Ritalin, Dexedrine and Cylert (Hall & Gushee, 2002). There is much to be concerned about when children take stimulant medication over a period of time. One concern is the range of side effects related to stimulant intake. These include decreased appetite, anorexia, insomnia, stomachaches, headaches, irritability, growth problems, tic development, drug abuse, increased blood pressure and/or 'the rebound effect' when stimulant medication is suddenly withdrawn (Kollins, Barkley, DuPaul, 2001; Hall & Gushee, 2002). Another concern is the lack of 'less than moderately active monitoring' of students on medication, as revealed by Demaray et al's (2003, p. 593) national survey.

The literature stresses the importance of managing children's ADHD behaviours via a multimodal approach. For example, Brown (2000, p. 6) supports the use of 'additional intervention directed to building requisite academic and social behaviour'. Other literature suggests that increased parent management training (Kollins, Barkley &

DuPaul, 2001) and collaboration between the child's parents, cousellor and teacher are crucial factors in helping children labelled as ADHD to be 'successful' in the family and school environments (Edwards, 2002; Vereb & DiPerna, 2004). While this suggests that increased parent education and appropriate school environments may assist children in managing their ADHD behaviours, little current research exists on these alternative options. The ease of access to medication may keep involved parties from exploring more educationally relevant interventions.

Other contestations in the literature revolve around the suggestion that ADHD is overdiagnosed. For example, Carle (2000) suggests that Ritalin is being administered to children to stimulate their concentration in an attempt to artificially boost their academic performance. A more recent concern that has arisen in the literature relates to the diagnosis and management of gifted children with ADHD behaviours. There is limited evidence that some of the commonly recommended interventions for ADHD children may make problems worse for gifted children who exhibit ADHD behaviours (see Moon, 2002; Neihart, 2003; Hartnett, Nelson & Rinn, 2004). Tait (2005) reviews and considers five theories about ADHD behaviours: it is a condition which can be objectively diagnosised; its diagnosis is subjective; it is an invention of the pharmaceutical giants who are motivated by profit; ADHD behaviours are 'normal' childhood behaviours; and, ADHD is a form of social governance. Tait (2005) concludes that ADHD is a theory that has yet to reach the status of 'established truth'. He justifies his findings on the basis that the scientific community itself cannot agree on any aspect of the disorder: 'its prevalence, its symptoms, its consequences, its treatment, its boundaries, its aetiology, its longevity, or its constituency' (Tait, 2005).

Despite the inconsistency and controversy surrounding the origins, diagnosis and management of ADHD behaviours, students are still being labelled as ADHD. This paper is not primarily focused on contributing to these debates, rather, this research examines the discourses labelled students use to talk about ADHD. In doing so, the social construction of ADHD identities, as it relates to two young boys, is made known. In theoretical terms, socially constructed identities are 'continuously created and re-created in each social situation' (Berger, 1963). Sarup (1996) refers to the contradictory and fractured notion of identity as 'the subject in process' (1996, p. 47). Fairclough (1992) terms these sorts of social practices as 'discursive events' and explains that they are 'ideologically loaded' in that the discourses that are implicated can help produce and reproduce unequal power relations between groups. Fairclough theorises that discourses within a discursive event are dialectical in the sense that they are shaped by 'situations, institutions and social structures' while at the same time constituting 'situations, objects of knowledge, and the social identities of and relationships between people and groups of people' (Fairclough & Wodak, 1995, p. 258). It is this two-way dimension of discourse that provides the space for particular identities to be taken up, sustained, contested and re-negotiated. The following section introduces the research study that explored the discourses of ADHD identity formation as understood by two young students labelled as such.

Research Study

The data for this paper has been collected via semi-structured interviews with two boys labelled as exhibiting ADHD behaviours by medical specialists. Both boys are students of Stuart's Independent College[2], a coeducational school located in a metropolitan city in Australia. The school caters for approximately 500 day students from Year 1 to Year 7. Parents of this school would be considered to be of a middle class socioeconomic status (*cf.* Connell, Dowsett, Kessler & Ashenden, 1982:12). Stuart's Independent College boasts impressive results in inter-school academic, sporting and cultural activities. The school comprises well-maintained buildings and gardens, and colourful, spacious and well-resourced classrooms. Parents of students pay annual tuition fees and a 'voluntary' building fund contribution. Uniform requirements account for another large expense, with the college uniform consisting of a dress hat, a tie for both boys and girls, and specially monogrammed garments. The philosophical focus of school publications is on the delineation of those factors seen as integrally tied to the objectives and attainment of a successful education. For Stuart's Independent College, this is interpreted as measurable academic achievement, sporting prowess and a high level of participation within a cultural program.

To protect the identity of the students, the fictitious names of Anthony and Benjamin are used. Although details about the boys' family contexts were known and collected, ethical considerations prevent the inclusion of this information in public forums. Interviews with each of the boys occurred separately, for reasons of confidentiality and to prevent them from merely echoing each other's response. At the parents' discretion, Benjamin's interview took place in a classroom after school hours, and Anthony's interview was conducted in the lounge room of his home during school holidays.

According to Ferguson and Halle (1995), interviewing lends itself well to generating information about the perspectives of others. It is thus a valuable tool for research because it gives a personal dimension to a lived experience (see McLean, 1991). Semi-structured interviews allow respondents to add to the range of topics open for discussion. Problems that impede the quality of interviews with young children include the adult-child power relationship and children's perception that they must provide the 'right' answers (Hatch, 1990). Coles (1990) also identifies difficulties of working with young children, particularly when deeply personal information is required. Interviewing techniques with young children can be improved upon by ensuring positive personal relationships between researcher and child are established and maintained (Coles, 1990; Hatch, 1990). Such a relationship minimises the likelihood of young children giving misleading answers.

Techniques that I employed to assist with the demands of interviewing these two young children included collecting data from students who attended a school where I was a visiting teacher and therefore known to both boys and their families. Due to the boys' ages, and to ease into the discussion about inappropriate behaviour, I brought along my toy puppy. Puppy is a soft cuddly toy, medium brown in colour, with long floppy ears. I introduced Puppy to each of the boys. I involved them in a discussion about the fun

[2] Place names and participants' names are pseudonyms.

times Puppy and I have together. I then turned the discussion to his at-school behaviour. I said, 'Puppy has been getting into trouble at school. His teacher said he was calling out in class, not finishing his work, and fighting at playtime. I just don't know what to do with him'. I waited for any impromptu responses. Some follow-up questions on the interview schedule were as follows:

- **Defining Behaviour:** If the teacher were to write a report about Puppy, what would it say about his school work? His behaviour? His group work? Play time? Could the teacher help Puppy control his behaviour? How? What would Puppy's friends say about his behaviour? What might Puppy's behaviour be like at home?
- **Social Divisions:** Are there any student groups in this school? Would Puppy belong to any of these groups? Do you belong to any of these groups? What do you have in common with your group? What makes you different from other groups?
- **Social Identity:** What can you tell me about yourself? What do you like the most about yourself? What would you change about yourself if you could?
- **Power:** Can you tell me what the rules are at playtime? What happens if students break these rules? How do teachers know if students break these rules?

An anlaysis of the interview data reveals that the boy's mis/understanding of the identities of ADHD evolves out of two discourses: the normalised school child discourse and medical discourses. Both discourses are meshed together within the boys' interview responses, introduced and analysed in the following section.

Discourses of ADHD Identity Formation

Very early in their separate interviews, both boys spontaneously suggested that Puppy could have ADD [sic]. For example, Anthony advised me to take Puppy to a doctor to have the diagnosis of ADD [sic] confirmed. Extract One, below, documents the discussion where he describes ADD [sic] to me.

Extract One:	
Researcher	*Do you know what ADD [sic] is?*
Anthony	*Unacceptable behaviour.*
Researcher	*How do you think the doctor knew that my Puppy had ADD [sic]?*
Anthony	*Because of his bad behaviour ... Um, his school work is good but behaviour is bad sometimes.*
Researcher	*What do you think the teacher will say about his behaviour during school time?*
Anthony	*(long pause) Bad*

Anthony draws on the discourse of a normalised school child to describe which behaviours indicate an ADD [sic] identity. Within the discourse of normalised school child, good school work is a desirable trait. However, according to Anthony's talk, a sought after attribute is negated when behaviour is bad. This extract of talk suggests that Puppy's *bad and unacceptable behaviour* would give him a deviant identity. Later on in the same interview, Anthony responds to a question about what Puppy does at playtime. His response, detailed below in Extract Two, suggests that the outcome of a deviant

identity would be that Puppy would be excluded from the social network of the play ground.

Extract Two:	
Anthony	*They'd say, 'You can't play with us. Play with someone else'. They'll say, 'No'. The other ones will say, 'No'. No one will want to play with Puppy ... Because they won't let him play ... They say, 'Go away!'*

In his interview, Benjamin also describes ADD [sic] as exhibiting *bad behaviour*. He too draws on the normalised school child discourse to explain what is considered to be 'normal' school child behaviour vis-à-vis what is considered to be 'typical' ADD [sic] behaviour, that is, 'abnormal' or deviant behaviour. In another part of Benjamin's interview, I asked if Puppy would discuss his 'ADD' [sic] with his friend. Benjamin suggested that Puppy would not do this. Extract Three, below, documents the interview talk between Benjamin and me.

Extract Three:	
Researcher	*Do you think that Puppy would tell his friend ?*
Benjamin	*No.*
Researcher	*Why not?*
Benjamin	*Because ... wouldn't have told them because they would have teased him.*
Researcher	*Do you think Puppy's friends know that he has to have medication?*
Benjamin	*No.*
Researcher	*How come his friends don't know?*
Benjamin	*Maybe one person will know. That person may tell the others, but then he might get cross.*
Researcher	*Who might get cross?*
Benjamin	*The Puppy ... because maybe he doesn't want any one to know.*
Researcher	*Why would it matter if his friends knew?*
Benjamin	*They would not let him play in their games at lunch time*
Researcher	*Why wouldn't they let him play?*
Benjamin	*Because they might not know that you can't catch ADD.*

In this extract Benjamin tries to make sense of ADD [sic] behaviours by drawing on a medicalised discourse. He claims that other children may believe that ADD [sic] can be *caught*, that is, that ADD [sic] is a disease. While his talk suggests that he knows that ADD [sic] cannot be caught, he believes that an ADHD identity should be silenced, especially if Puppy doesn't want to be teased. Aware of the negative potential of particular ADHD identities, Benjamin continues to warn me that Puppy's ADD [sic] identity should remain silent. In response to my question about the ways that the teacher could help Puppy in the classroom, Benjamin continues to provide the same advice in Extract Four.

Extract Four:

Researcher	*Is there something that the teacher could do to help Puppy in class?*
Benjamin	*Um, make the other puppies not tell a word about his ADD [sic], not say a word about his ADD [sic].*

In a part of the interview when we were talking about playground friends for Puppy, I asked Benjamin what he thought Puppy would do at playtime. Benjamin continued to highlight the other children's misunderstanding of the ADD [sic] condition.

Extract Five:	
Researcher	*What do you think Puppy would do at playtime?*
Benjamin	*Just play by himself and that.*
Researcher	*So what would Puppy do if he wanted to go and play with another group of Puppies?*
Benjamin	*Ask.*
Researcher	*What do you think the group would say?*
Benjamin	*No.*
Researcher	*Why would they say no?*
Benjamin	*Because they might be able to catch the ADD.*
Researcher	*Oh, they can't, can they?*
Benjamin	*I just think so, because how did Puppy catch it?…Because it's a bad disease and it makes him get out of his seat and do bad things like call out.*

Benjamin's response suggests students labelled as ADHD present as a danger, a pathology, that must be avoided at all costs. An analysis of his talk suggests that within the discourse of normalised school child, an identity of ADHD establishes patterns of social relations of exclusion that do not permit labelled students to enter the inside of the social context of the playground. While in Extract Three Benjamin suggests that the other children misunderstand the ADD [sic] condition as something that can be caught, he takes up these same beliefs in this extract. He labels the condition as *a bad disease.* Benjamin's theory is supported by his idea that Puppy must have caught the disease, questioning me, *[h]ow did Puppy catch it?*

In the interviews I also asked both boys how a teacher could help my Puppy to change his behaviour. The responses from both Benjamin and Anthony suggest that my Puppy needs to be made 'normal', that is, 'be normalised'. They both draw on medicalised discourses to suggest that I need to medicate Puppy to make him 'normal'. Anthony, for example, believes that Puppy exhibits ADD [sic] behaviours when he's forgotten his medication.

Extract Six:	
Researcher	*Why do you think Puppy is good during group work but he has problems during play time?*
Anthony	*Because I think he's forgetting his tablets.*
Researcher	*Are the tablets that important?*

Anthony	*Yeah.*

On two occasions, I asked Benjamin to nominate strategies a teacher could use to assist Puppy to control himself. On both occasions Benjamin indicated the need for Puppy to be medicated.

Extract Seven:	
Researcher	*What are some of the things that [Puppy's] teacher can do to help remind [Puppy] to control himself?*
Benjamin	*Maybe, um, ask his Mum and Dad to give him four tablets.*

Extract Eight:	
Researcher	*Do you think when Puppy is getting a bit out of control there is a sign that the teacher could give to Puppy to help him to get back into line?*
Benjamin	*... Like a big tablet that will make him have self-control.*

I then asked Benjamin how would Puppy feel about having to have medication. His response is in Extract Nine, below.

Extract Nine:	
Researcher	*How do you think Puppy feels about having to have medicine?*
Benjamin	*Quite happy.*
Researcher	*Happy? Why might the medicine make him happy?*
Benjamin	*Because he might get better and [the medication] might make [the ADHD] go away. He may be better at school and at home.*

Extracts Six, Seven, Eight, and Nine suggest that both Anthony and Benjamin believe medication to be the answer to the problem of rule-breaking behaviour. Benjamin understands ADD [sic] as a condition that can be made *better* or *made to go away* by medication. However, the amount of medication that Benjamin is suggesting is in excess of the dose that he is presently taking as part of his 'management' of ADHD - two 10gram tablets each 24 hours. At one point Benjamin suggests that Puppy needs *four tablets* and then Benjamin suggests that Puppy needs *a big tablet*. These extracts indicate the importance both Anthony and Benjamin place on the need for Puppy to conform to normalised school child discourses and the part medication plays in this attempted re-formation.

Conclusion & Discussion

This research study highlights two young children's mis/understandings of the origins and management of ADHD behaviours. Both boys construct those with ADHD behaviours as deviant and as needing to be excluded from the social network of the primary school context. Both boys also draw on medicalised discourses to provide suggestions for dealing with ADHD behaviours. Of particular concern, was Benjamin's mis/understanding of ADHD as a disease, a disease that could be transmitted to others. These findings should be of immediate concern to those involved with the diagnosis and

management of ADHD behaviours. Care should be taken to ensure young children have adequate and reasonable understandings of the origins and management of such conditions. Misunderstandings such as the ones revealed in this research study should be corrected, however, doing so is easier said than done. As the earlier review showed, even those involved at the forefront of research into ADHD cannot agree upon the origins and management of such behaviours. Yet, it is clearly important that young children should not be left to their own devices to make sense of their socially constructed identities.

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